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Discussions

Looking back moving forward: The history of midwifery in Western Australia

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ABSTRACT

Problem: To date there is has been very little research into midwifery in Western Australia (WA), therefore this paper addresses a significant gap in the literature. The aim of this paper was to gain insight into the history of midwifery in WA.

Background: Since the beginning of recorded history midwives have assisted women in childbirth. Midwifery is recognised as one of the oldest professions; midwives are mentioned in ancient Hindu texts, featured on Egyptian papyrus and in The Bible. Up until the seventeenth century childbirth was the responsibility of midwives, but the gradual emergence of barber-surgeons, then man-midwives and obstetricians heralded a shift from women-led and community-supported birth to a patriarchal and medical model. Throughout the twentieth century childbirth practices in the Western World have continued to change, leading to a move from midwifery-led care at home to doctor-led care in the hospital.

Discussion: The first non-Indigenous Australian midwives were not formally trained; they came on ships bringing convicts to Australia and are described as 'accidental' midwives, as assistance in childbirth came from whoever was available at the time. This period was followed by what was called the 'Aunt Rubina' period where older married women helped younger women in childbirth. Throughout the early 1800s untrained or 'lay' midwifery care continued alongside the more formally trained midwives who had arrived with the colonists.

From the early 20th century, when birth moved into the hospital, midwives in WA have been incorporated into the hierarchy of the professions with obstetrics as the lead profession and midwifery considered a speciality of nursing. The role of the midwife has been subordinated, initially controlled by medicine and then incorporated into the institutions and nursing. The increase in legislative and training requirements for midwives throughout Australia and the move from home to the hospital, gradually led to the decrease in autonomous midwives working within the community, impacting women's choice of birth attendant and place of birth.

Conclusion: The historical suppression of midwifery in Australia has impacted the understanding of the role of the midwife in the contemporary setting. Understanding the development and evolution of the midwifery profession in Australia can help future directions of the profession.

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Statement of significance

Problem

To date there has been very little research into the history of midwifery in the Western Australian context.

What is already known

The history of midwifery in areas of the world such as the UK and Europe has been well researched and documented, however in Australia, much of this research has focused on the Eastern States.

What this paper adds

This paper provides a history of midwifery in Western Australia. Understanding the development and evolution of the midwifery profession in Australia can help future directions of the profession.

1. Introduction

Drawing on primary and secondary sources, this paper provides a history of Australian colonial and post-colonial midwifery with a focus on Western Australia (WA). To date there is has been very little research into midwifery in the WA context, therefore this paper addresses a significant gap in the literature. The authors acknowledge and pay their respects to the past Aboriginal and Torres Strait Islander midwives of Australia; however, this article will not discuss their experiences or practices and recognises that there is a deficit in this knowledge, which unfortunately is beyond the scope of this paper. The history of midwifery in WA is not linear, therefore this paper presents this discussion and analysis using subheadings. It is difficult to present the history using timelines alone, as some events had consequences and impacts in multiple or overlapping timelines.

In its simplest terms, archival research is the methodology of gathering information from primary sources [1]. Archival information was gathered from primary sources about midwives and midwifery in Western Australia from 1830 to 2018 and combined with existing secondary research on midwifery in WA. The data included recorded stories (such as diary excerpts and family histories), newspaper articles, government documents and maternity health policies and guidelines. Primary resources can be understood as firsthand accounts of an event or subject of interest. These can take the form of documents created by people who participated in or witnessed an event [2,3]. McAllister and Lewenson [4] state that the exploration of archives and assessing the availability of primary and secondary sources are the key to developing the historian's research. The work of the historical researcher involves sourcing these primary resources, analysing them within the context they reside and considering the genuineness and authenticity of the material [2,4,5]. To be genuine and authentic the document must provide a truthful report of the subject and be what it says it is; however, it is worth remembering when analysing these documents that the 'truthful report' is still the author's interpretation of events. Secondary sources use primary data to tell a story: they are sources based on the primary data; in other words, they are materials that put forward opinions and interpretations of the primary sources [5]. Secondary sources can provide a contextual background to the subject under study or a specific period [2]. The search for primary and secondary sources was conducted using State Library and State records office search functions along with the internet, google searches, digital databases like TROVE and accessing references from scholarly articles. The archival research was comprehensive and drew upon data from multiple sources. Archival research was undertaken in archives at the Battye Library in Perth, the State Records Office of Western Australia, the museum at the King Edward Memorial Hospital in Perth, the Fremantle Museum and State Museum Library.

2. The first non-Aboriginal and Torres Strait Islander midwives

The first non-Aboriginal and Torres Strait Islander midwives in the Swan Valley Colony (the first established colony in Western Australia), similar to other parts of Australia, were untrained convict women. They came on the ships bringing prisoners to Australia and can be described as 'accidental midwives'; assistance in childbirth came from whomever was available at the time [6]. The 'accidental midwives' expertise in midwifery is unknown. There was no other option for women, but for friends, relatives, and neighbours to help each other during birth, thus women became midwives through need rather than vocation. This early colonial situation was followed by what was called the 'Aunt Rubina' period where older married women helped younger women in childbirth (Thornton named the 'Aunt Rubina midwives', after her Great-great Aunt) [7]. Throughout the early 1800s untrained or 'lay' midwifery care continued alongside the trained midwives who had begun to arrive as free settlers [6,8]. Potter [9] describes three types of midwives in the early days of occupation in Sydney. The first group were the convict 'accidental' midwives. The second group comprised free migrant women; many were widows with children to support, who would have practised midwifery in their home country. The third group were certified and trained midwives, who had obtained their midwifery qualifications overseas [9]. Evidence suggests that the situation was similar in the Swan River colony. These early midwives of Australia, unlike their British and European sisters, lacked organisation, cohesion and consistency [9–11].

3. The pioneer period: midwives of the new colony 1829–1880. 'Neighbouring, Aunt Rubinas' or nothing?

Western Australia was invaded in 1829 when Stirling and his men arrived on *The Parmelia* with their wives and families, about sixty staff and settlers as well as stores and equipment [12]. Some babies were born at sea and the captain's wife, Mrs Ellen Stirling, was among the women to give birth on the voyage. Archival evidence indicates that many of the new arrivals were pregnant, therefore midwifery care was needed from the moment the settlers arrived in the Swan River Colony (which later became Perth) [12]. Compared to the services that were available in Britain, the pioneer women had to 'make do' with help from whomever could provide it and if no help was forthcoming, they had to birth alone. Some historians assert that medical men provided assistance in birth from the beginning of the settlement; however, there were very few doctors in the new colony and their midwifery skills were questionable [13,14]. In Europe, by the mid-1800s medical men had started to become involved in the provision of midwifery; however, this was generally confined to women of middle and upper-class status and was still not a universally accepted practice.

Like much of women's history of this time, there is little documented evidence of early colonial midwives in WA. There are no surviving documents from the midwives themselves. Many of the working-class women would have had limited literacy skills. There are limited surviving records in the diaries and letters of the middle and upper-class pioneer women and from the histories of pioneering families [15]. These records illustrate that in the early days of the colony, women had help in childbirth from anyone who was available. Birth took place in the home, as was the norm [15].

Many historians use the terms nurse, nurse midwife and midwifery nurse interchangeably; attendants at births were also often referred to as 'nurses' and this has contributed to the lack of awareness of the role of the independent midwife in WA [15,16]. Although it was not uncommon for babies to die in other countries such as Britain, the conditions the Australian pioneer women were living in and the lack of skilled support during childbirth, contributed to the deaths of infants in the new colony [15].

The letters of Eliza and Thomas Brown illustrate the life of early settlers in the Swan River colony. In a letter, dated March 21, 1841, Eliza

described how her family and all passengers disembarked the ship, and how a woman was left aboard to attend to Mrs Forster, the chaplain's wife in her approaching birth: "Ann was left behind to attend on Mrs Forster the chaplain's wife who is in a very sad state of health [17 (p.9)]. She will remain to nurse her in her approaching confinement and join us when the ship has discharged cargo which will take three or four weeks yet to accomplish" [17 (p.9)]. The letter does not state whether Ann was in fact a midwife or acting in the 'Aunt Rubina' role to support Mrs Forster.

Although there was a high infant mortality rate when compared to modern standards, the infant mortality rate in the Swan River Colony was not excessive for the time and was generally better than rates in England [15]. Rather than problems associated with the actual birth, the infant mortality rate was more likely due to the health of the pioneer women and their living conditions. Childbirth was generally uneventful and considered a part of everyday life. In general, untrained and trained midwives attended most births in the early years of the colony. Doctors had started to attend births in Britain, therefore the middle- and upper-class women of the colony may have expected doctors to care for them during birth, however, as there were so few doctors, they had difficulty accessing them. Doctors were generally only sent for if there were complications which was not the case for many women, rich or poor. In particular, the women who lived in remote areas of Western Australia had no skilled assistance, and gave birth either alone, or with assistance from Indigenous women, or neighbouring women.

4. Medical doctors of the colony 1829–1880

Some historians have argued that from the beginning of European occupation in Australia, childbirth attendance was predominantly by medical doctors [17]; however, contrary to this belief, the doctors were not called to all births, and even when called they did not always attend. In these cases, the doctor was sent for only once it became apparent that the birth was becoming difficult. It is also worth noting that the skills that these doctors possessed would have been vastly different from our expectations today. Few of the colony's doctors had 'recognised' qualifications [18]. In Britain until the introduction of the *Medical Registration Act 1858* [19], British doctors were not registered, and only since 1815, were British doctors required to follow any recognised course of study or apprenticeship [20]. Medical registration laws were not passed in Western Australia until 1870 [20]. The first *Medical Register* was published in the Government Gazette on 20th April 1870 [21]. Seventeen doctors were listed; of these, only ten were documented as having any formal qualifications, the remaining seven were able to register as medical practitioners due to their long and proven service in the profession [22]. The population census of 31st March 1870 recorded a total population of 24,785 European settlers, of which 9410 were female 20; therefore, it is unlikely that doctors attended many births in the colony. The small number of doctors in the colony also had their share of ill fortune and 'bad luck'. Many died through disease, accidents and other causes, reducing their number further [23].

It is evident that some settlers had doubts about the quality of medical care offered by practitioners. Louisa Clifton settled at Australind, south of Perth, with her husband in 1841 [24]. Louisa was concerned about the lack of medical care and the level of skills of the medical men in her community. She wrote that she had observed the local doctor, Dr Carpenter, on the voyage to Australia and was deeply concerned by his lack of hygiene, particularly the state of his hands, and she found him lacking in medical skills and professional behaviour [24]. Following their settlement, Louisa continued to have concerns. After a young woman, Mary McGlashen, died, Louisa was highly critical of the doctor's involvement in her care as she did not believe the woman received proper medical treatment. She blamed Dr Carpenter for McGlashan's death, because he "said one thing, then another" in his diagnosis [24 (p.196)]. Louisa repeated what she said many times before "that the poor women deserved better than the incompetent doctor" [24 (p.197)].

5. Midwives as working women and the arrival of overseas 'trained' midwives

The first census for the Swan River Colony was completed in 1859 and although it records employment, it only records employment data for men; therefore, there are no records of midwives working until much later when the *Australian Post Office Directory* was established in 1893 [25]. As the population expanded, more midwives were available in the colony; by the 1860s women had begun to earn a living as midwives, advertising their services in the newspapers. In 1863, Mrs Gaunt advertised her services in *The Perth Gazette*, to inform the ladies of Perth that she intended "to practice the office of a midwife in the city of Perth" [26]. The advertisement highlighted her association with medical doctors as a reference for her skills as a midwife also demonstrating the growing importance of medical practise and the social success of medicine [26]. Another advertisement in the same year, published the services of a medically trained midwife, Mrs McNee, "A Matriculated Nurse and Midwife, from the Royal Maternity and Inlying Hospital, Edinburgh, pupil of Alexander Keiller M.D." [27]. A third midwife, Anne Louisa McCaffrey, advertised her services as a "fit and proper person to act as a midwife" [28]. McCaffrey also detailed her experience and training — four years of working in a lying in hospital and under the guidance and supervision of two medical doctors — attempting to create a distinction between the untrained midwife and the trained midwife to highlight her expertise.

In paying for advertisements, all three midwives demonstrated their attempts to differentiate between the 'accidental' and 'Aunt Rubina' midwives and the more affluent and professional midwives. Advertising their services in a newspaper had associated costs; therefore, it indicates that these midwives had the funds to promote themselves and their midwifery services. They were advertising to women who could afford to buy and read the newspapers, and willing to pay for attendance at their births, unlike the reciprocal 'neighbouring' described in the letters and diaries, which would not usually have a fee associated with the care provided [15]. The apparent need for these midwives to promote their association and training with medical doctors highlights the changing society and expectations of care in childbirth, and the type of women the midwives were attempting to attract. These three women were the only midwives who advertised their services in the press during the mid-1800s in the colony, with advertisements appearing in newspapers throughout the 1860s and into the 1870s [15]. There would be no need for constant advertisements to maintain a clientele, however, as midwifery was often a 'word of mouth' profession. This is demonstrated by the advertisements that Mrs Gaunt placed in *The Inquirer and Commercial News* in 1863 and 1865 to inform women that she had moved residence [29,30].

With the increase in population and social changes in Perth, benevolent charities were needed. Additionally, there was no government support for midwifery services. The first of the benevolent charities was known as 'The Servant Home', designed to provide a refuge for destitute single women. Within a few years the Servants Home became known as the 'Poor House' [31,32]. Many poor women did not have the money to pay for care during childbirth, and where possible, they sought help from the Poor House, with the risk of being turned away [15]. Concerns about the 'wrong' sort of women seeking the assistance of the Poor House existed from the beginning. In 1856, the Immigration Officer, Mr Alfred Durlacher, wrote to the Governor regarding the use of the Poor House: "if every woman who pleads poverty or inability to work be admitted into the Poor House in Murray Street without regards to character, the establishment will soon not only be a refuge for the honest and unfortunate, but a Magdalen and a lying in hospital" (Magdalen is a term used to describe a 'fallen' woman or prostitute, it comes from the reformed prostitute, Mary Magdalen, in the Bible) [33]. In 1864, John Stone, the officer in charge of the Poor House, detailed concerns about

women seeking to be admitted to the Poor House to birth. He stated in a letter to the Colonial Secretary that, "A woman named… had applied for admission into the Poor House for a short time, and from the inquiries I have made, I have ascertained that she seeks admission for the purpose of being properly attended to during her confinement shortly expected…" [33 (p.48)]. Rather than admit her to the Poor House, Stone sought "the approval of His Excellency, if I direct the Poor House Midwife, Mrs Gaunt, to attend the woman at her own house, which is at no doubt all that is required; or, on the other hand, if I'll inform her that no assistance can be given her by the government" [33 (p.48)].

In the colony of Swan River as in Britain and other colonies, the social expectations of women meant that having a child out of wedlock was deemed shameful. There was no government support for poor women and the difficult social conditions and sexist attitudes of the time made having a child out of wedlock extremely challenging. Poor single women with no family or means of support, may have felt they had no other option than to resort to infanticide. Multiple cases of this are recorded in the legal records and newspapers of the times. In July 1840, a young woman was charged with "wilful murder" of her "illegitimate child" [22 (p.314)] and another woman, Catherine Kelly, was charged and brought to trial for "wilfully murdering her newly born male child on 18 September 1862" [22 (p.78)]. Kelly had given birth unaided in the lavatory of the Poor House and the child had been found in the pit underneath the lavatory. She was found not guilty, as it was difficult to prove that the infant was wilfully killed [22 (p.78)]. By the middle of the nineteenth century the lesser charge of 'concealment of birth' was more likely, if a woman was charged regarding the death of her infant. Mary Allen in 1859 and Louisa Lund in 1867 were both charged and found guilty of concealment of birth [34,35].

As the population of the colony expanded there were not enough trained midwives or doctors to attend all births; therefore, the empirically trained midwives and the Aunt Rubinas continued to provide midwifery along with the trained midwives until the early twentieth century [15,22,36]. The Annual Report of the Colonial Surgeon for the year 1875 details how health and sanitation in the colony was improving [37]. The death and birth rates for the year 1875 were reported as: registered births, seven hundred and sixty; registered deaths, four hundred and seventy-three. Therefore, the death rate was recorded as seventeen in every thousand. Of these deaths, ninety-six were of infants under the age of one and sixty-five of children aged one to five [37]. It is worth noting that it is unlikely that all deaths and births were recorded or registered. The Health Report featured in *The West Australian Times*, also highlights the difficulty in procuring medical aid in widely scattered districts [37]. Infant mortality was appropriately highlighted as an area for concern; however, this was to have repercussions on midwives and their practice in the following decades.

6. The transitional period 1880−1910

The period from the late nineteenth century into the early twentieth century is described by Willis (1989) as the "Transitional Era". During this period nursing began to evolve as an occupation and the medical profession gained power and influence within the colony and later the state [38]. In Australia, both these events and the changes in the socio-political environment led to the absorption of midwifery into nursing and the associated subordination of midwifery to medicine [38]. This enabled nursing and medicine to gain increased control over midwifery and led to legislation which placed restrictions on midwives' practice, leading to the loss of autonomous midwifery practice and their distinct role as a profession separate to nursing [36,38]. The subordination of midwifery was achieved in Australia even though midwives had community support, because they lacked a professional organisation and had no institutionalised backing [38]. Of particular relevance to the ease with which the subordination of midwifery was achieved, is the gender and class divides between medicine on the one hand, and nursing and midwifery on the other. The majority of midwives in Australia at the end of the nineteenth century were still working-class and all were women.

7. Changes in WA and the development of the hospitals

In 1890 the Swan River colony was granted responsible government and a parliament replaced the existing system of Governor and Council [39]. Although the Governor remained as head of state, the colony had its first premier, Mr John Forrest. In January 1901 the federation of the 'Commonwealth of Australia' was formed and the colonies became states within the Commonwealth which led to the formation of State and Commonwealth parliaments [39].

With the discovery of gold and the resulting 'gold rush' of the late 1880s and 1890s, another major increase in the population occurred. The population quadrupled in the colony from 49,782 in 1882 to 179,967 in 1900 [39]. This substantial and rapid change in population and the associated poor living conditions contributed to widespread disease and poverty [39]. The worsening public health triggered increased government involvement in sanitation and public health issues and the establishment of public hospitals. In general, pre-industrial hospitals were institutions for the poor, the insane and the destitute. Patients had a variety of illnesses, not treated on a specialist basis, as the aim was not cure but treatment of symptoms [40 (p.160)]. In the late 1800s more benevolent societies started to arrive in the colony. In 1891, The Salvation Army established its headquarters in Murray Street, Perth and started to aid the poor and disadvantaged of the community, including in the Goldfields region [32]. Other religious benevolent groups, The House of Mercy, the Sisters of the People and the Sisters of the Order of St John of God also provided nursing care throughout the colony establishing hospitals in the Goldfields and Perth [32].

8. Hospitals and lying-in houses

By the 1880s throughout Australia, rather than just the reciprocal 'neighbouring' during childbirth, midwives working within their communities were able to earn a living from attending births [15]. Throughout the nineteenth and early twentieth centuries in Australia, the majority of women still gave birth at home; however, the lying-in house became another option [41–43]. Increasingly, towards the end of the nineteenth century some midwives began to offer this service. Therefore, the midwives, rather than just attending women at home, would also provide midwifery care to women in their own residence; this was the beginning of the Australian lying-in homes and 'private maternity hospitals' [15,36]. By 1910, there were advertisements for maternity homes and a medical section in most newspapers [15]. Some midwives who advertised, were clear to distinguish themselves from untrained midwives, listing qualifications, experience, and association with medical doctors [15,36]. These hospitals and lying in homes were owned and operated by the autonomous and independent midwives. However, moving into the 20th century they became larger and more medically controlled [15].

9. Baby farming

In the early years of the twentieth century, infant mortality in WA continued to cause concern for policy makers. For eleven of the first twenty years of the new century, WA had the worst infant mortality rate of any state except the Northern Territory. The 1904 report of the NSW Royal Commission into the decline of the birth rate made special mention of WA's poor track record and had no hesitation in blaming midwives [15]. Public disquiet about these findings led to growing pressure on the state government to take a more interventionist approach to maternity care and infant health. Things accelerated in 1907 after a highly publicised case of 'baby farming' was uncovered [44]. At this time, unmarried mothers who had to work to survive, were regularly forced to leave their babies in infant boarding houses under the

care of nurses. Baby farming was the term used to describe this type of fostering for a fee. In this case, nurse Alice Mitchell, was found guilty of wilful starvation and culpable negligence after a baby died in her care [15,44].

While 'baby farming' was not necessarily linked to midwifery practice, the state government response to the Mitchell Case nonetheless had a significant impact on midwives in WA. Following this high-profile case, *The State Children Act* was passed in 1907 [45] and lying-in houses now had to be registered; but there was still no official midwifery training or registration of midwives in WA. Midwifery training had commenced in other Australian states in the late 1800s; however, the demand for midwifery care was higher than the number of trained midwives, so untrained midwives continued to provide care in all states [36].

10. The hierarchy of the professions in Australia

The status of medicine in the nineteenth century was low throughout Australia. To ensure that medicine became a high-status profession it was important for medical doctors to be autonomous and differentiate themselves from the alternative practitioner or 'quack' [18,38,48]. One way to achieve a high-level status, was to professionalise [46]. Many definitions of 'profession' exist, however, the major distinction between a profession and an occupation is the legitimate and organised autonomy accepted by a profession and the recognition of specialised knowledge and skills obtained through formal and supervised training. This autonomy ensures the profession has an occupational monopoly and dominance within the division of labour [47]. Furthermore, autonomy and control are based on certain foundations, esoteric knowledge and the recognition and protection of that knowledge by the State. Therefore, the close links formed between medicine and the State ensure this position is maintained and prevents other 'lesser' professions from achieving the same status [47]. According to Willis, the medical profession dominates the health division of labour; economically, socially and intellectually [38]. Medical dominance is a key feature in the production, social structure and organisation of health care in Australia today and was achieved by the medical profession's autonomy and ability to self-govern. Importantly, medicine's professionalisation was also linked to issues of gender and class. As middle and upper-class men, medical doctors had significant connections to the state legislative apparatus, giving them the power to define the conditions under which medicine recognised and legitimised other health occupations such as nursing and midwifery [15]. With state support, medicine gained the right to deny the legitimacy of some health occupations to ensure that medicine remains dominant [18,38]. Willis [38] argues that once the medical profession achieved dominance in the division of labour, doctors were placed at a political and social advantage; dominance, through their involvement with regulation and legislation, continued in Australian society contributing to the enhanced status of the doctor and the power that position entailed [38]. This status combined with the advancement of 'scientific knowledge' such as the discovery of anaesthetics in the 1840s and antiseptics in the 1870s led to a new era of medicine. Diseases were treated effectively, and surgery was conducted safely. In Australia, the medical profession also benefitted from improvements in public health and sanitation. The introduction of government controlled public health schemes and the implementation of safe sewerage disposal led to general improvements in health and the accompanying reduction in disease [6,49]. The fall in mortality witnessed at this time was more likely attributed to the overall improvement in general living conditions in most of Australia [39], rather than the advances in the 'scientific' profession of medicine. However, there is no denying that the medical profession gained more professional credibility, in conjunction with their gender and social class, from these public health advancements [6].

11. The arrival of the Nightingale nurses in Australia

Formal nursing was introduced into Australia in the 1860s, when Lucy Osborne, a Nightingale trained nurse established a training school at Sydney Hospital in 1868 [50]. Previously, hospitals existed only as charitable institutions for the destitute and care was provided by untrained men or Catholic nursing sisters. The arrival of the Florence Nightingale trained nurses, who worked within hospitals, led to nursing being accepted as a suitable type of employment for middle-class young women across all Australian states. This new style of nursing began to change how nursing was understood previously—care provided by untrained and uneducated workers—to a profession for 'ladies' that required education and training [50 (p.181)]. The new nurses had to attain a certain level of education but also to maintain certain social and moral standards. In contrast, the independent midwife was more likely to be older, working-class and 'untrained', having learned her trade by experience.

Unlike the autonomous independent midwives, nurses were not expected to make independent clinical decisions; their role was to observe and report findings and observations to the medical doctors [16]. Thorogood believes that medicine's acceptance of hospital based midwives in WA provides unequivocal evidence that the early struggle between medicine and midwifery, was not about the midwives' competence but due to their status as independent practitioners [16 (p.43)]. The doctors, therefore, were opposed to any move to make midwifery an independent profession as they wanted to prevent the independent midwives from improving their status and standing in the community. Ultimately, the move to incorporate midwifery into another female-dominated occupation—nursing—would ensure that the working-class female midwives would continue to be excluded from medicine (as midwifery was now being defined as part of medicine under the new speciality of 'obstetrics') and bring the midwives under medical control. In Australia, towards the end of the nineteenth century there was a push for the registration of nurses and midwives. A Bill to register midwives was presented to the New South Wales Government in 1898 [51]. The conversation relating to this Bill demonstrates the belief that medicine already controlled nursing and highlighted the need for medicine to subordinate midwifery, or risk repercussions, as cited in Summers [52]:

> A nurse always means one who is subordinate to the doctor, who acts under his orders, and has no independent authority. A midwife is one who does not necessarily act under the supervision of a doctor (so long as the case remains uncomplicated). She is individually responsible for the case under her charge. To call her a nurse, with whatever qualifying adjective, is to confuse one who has independent charge with one who has not, but who receives her orders from a superior [52 (p.16)]

The training of midwives was a matter of significant debate in medical circles in Australia. Training implied acceptance as a practitioner and many medical men wanted midwives completely removed from the picture. The only way that medicine could control midwifery was through nursing. If midwifery became a branch of, or was included in nursing, then it too would fall under the control of medicine [38]. To be able to control midwives, medical doctors also had to control who could train and practice as a midwife. Consequently, medicine accepted the training of midwives under certain circumstances — training in hospitals under medical supervision, a minimal amount of training and skills, and a strict eligibility criteria that excluded most of the practising working-class midwives [15,38]. Training was designed to enable midwives to provide care within the medically controlled and supervised institution, but was not comprehensive enough to enable them to provide the full scope of midwifery practice, thereby discouraging midwives from entering into autonomous independent practice.

12. The takeover period 1910–1950

The periods from 1910 to 1950 is described by Willis as The Takeover period [38]. The 1912 Commonwealth-funded *Maternity Allowance Act* [53] gave a financial payment of five pounds to all white women following the birth of a child. Aboriginal and Torres Strait Islander women and women of other ethnicities were not entitled to the payment [53], demonstrating that the government initiative was aimed at supporting *white* mothers and reducing the mortality of *white* children. The payment was considered a radical measure as it was paid directly to both married and unmarried mothers, therefore undermining the traditional patriarchal role of the husband [54]. The payment was considered a large amount of money, equivalent to two weeks wages for a man and five weeks wages for a woman. It was paid directly to women to ensure it was used specifically for the welfare of the mother and child [15]. This payment enabled women to pay for more expensive birth attendants and after its introduction, attendance by medical practitioners increased [15]. Thus, the early 20th century became a period of intense competition between midwives and doctors in Australia. For example, an editorial in the *Medical Journal of Australia* claimed that the lavish payment would lead to women being lured by the "midwife, keen as any shark in the cities" at the prospect of making money, and that the consequences would be an increase in puerperal fever [55].

Although there was a substantial increase in doctor attended births in and out of institutions during this period, there was no significant corresponding reduction in maternal or infant mortality [31,38]. Even by 1927, as medical attendance at births continued to increase, puerperal fever accounted for 36% of maternal deaths in Australia [15]. Despite the lack of evidence and contrary to the actual statistics, midwives were blamed for maternal and infant deaths [15].

Autonomous independent midwifery was in decline by the early to mid-20th century. The establishment of publicly funded maternity hospitals in Australia was a crucial obstacle to autonomous midwifery practice. The medicalisation of birth and medical dominance within the hospital, led to the state and medical control of the training and regulation of midwives. Once women began to birth in hospital, the specialisation of obstetrics completed the medical dominance of birth. By the mid twentieth century, with the centralisation of maternity services into hospitals, smaller nursing homes and smaller hospitals began to close throughout Australia [10,56].

13. Health Act of 1911; the registration and regulation of midwives

The *Health Act of 1911* [57] was the first legislation aimed at controlling and regulating midwives' practice in WA. Included as part of the bill under the title *'protection of life'* was the introduction of legislation requiring midwives to be registered. A Western Australian Midwifery Board was appointed under section 252 of the *Health Act* [57] which consisted of five members and was dominated by medical doctors. The Chairman of the board, Dr Hope, was the principle medical officer and the board consisted of two other medical doctors, Dr White and Dr Hicks, and two midwives, Matron Tate and Matron Harris [32]. The legislation dictated that:

> no woman shall be entitled to take or use the name or title of midwife or midwifery nurse or to keep, conduct or manage a private hospital wherein maternity cases are received, or to act as an assistant nurse in any such hospital unless she is registered under this Part of this Act. [57 (p.253)]

A midwife who was unregistered and attended a birth risked a fine of two pounds for a first offence and a fine of ten pounds for subsequent offences. However, this part of the legislation also provided a loophole for unregistered midwives attending a birth if there was no registered practitioner within a five-mile radius of the residence [57]. Registration required the midwife to prove her qualifications and training and pay a fee of five shillings or demonstrate that she had "been for at least two years in bone fide practice as a midwife and satisfies the board of her competence, cleanliness, and repute" [57 (p.255)]. Trained midwives were required to have undergone at least 12 months training at an approved institution and provide evidence that they had attended a prescribed number of cases. The Board also attained the right to remove a midwife from the register and to "make regulations for supervising, regulating, and restricting within due limits the practice of midwives, and for any other purpose tending to protect the lives of mothers and infants" [57]. Following implementation of the *Health Act* more restrictions and conditions were placed upon midwives, including what they should wear to births and what equipment they should carry:

> The Midwife must be scrupulously clean in every way, including her person, clothing, appliances and house…..when attending to her patients she must wear a clean dress of washable material that can be boiled, such as linen, cotton etc. And over it a clean washable apron or overall [58].

It was assumed that midwives were sloppy and dirty and needed direction to maintain appropriate standards; no equivalent orders were placed on medical doctors attending births in WA, which demonstrates that the standards placed on midwives were not about improving maternal and infant safety, but a method of control. The *Health Act* also determined the scope of midwifery practice and defined the situations in which the midwife should call the doctor to attend, including all deaths, as midwives were not allowed to complete a death certificate [57]. The midwife was also legislated to complete a birth notification for each birth attended [58].

The first register of midwives was published in the Western Australian Government Gazette on 2 January 1913 and listed 2 types of midwives; qualified midwives and 'unqualified' midwives [58].The 'grandmother' clause allowed 'unqualified' midwives to register. These women did not have formal qualifications but were empirically trained. Of the 863 registered in January 1912 only 122 held any certificates of training recognised by the Midwifery Board, 28 qualified midwives had trained at Fremantle midwifery training School and the remainder obtained their certification from other Australian states or Britain [15,32,58]. Subsequent midwifery registers showed an increase in qualified midwives, however many unqualified midwives remained on the register; after 1915 no new unqualified midwives were able to register in WA. Nurses in WA were not registered until the Nurses Registration Board began in 1921 [59]. Unlike the other Australian states, where by the 1930s midwifery was incorporated into nursing as a specialised branch of nursing, WA midwives retained their independent status from nursing until the 1940s. In 1944 the Midwifery Board was abolished, and the regulation of midwifery practice was incorporated under the States' *Nurses Registration Act Amendment Act 1944* [60]. Midwives were registered under Part V, The Midwifery Section of the Nurses Board Register, and the subordination of midwifery into nursing was complete [60]. After 1945 unqualified midwives were no longer included on the register.

14. Training of midwives

The teaching of midwifery developed alongside the training of medical students in obstetrics during the late nineteenth century in Eastern Australia, but midwifery training did not commence in WA until the early twentieth century [15,32]. The male medical staff provided formal education and instruction to the female midwifery students; however, Willis argues that their intent was not to educate the independent midwife, but to create the subordinated maternity nurse [38]. The first midwifery school was opened in Melbourne at the Lying-in Hospital which eventually became the Women's Hospital [61]. The medical staff were opposed to the training of independent midwives.

The 'Diploma in Midwifery' began in 1893, yet this training was offered only to formally trained nurses and enabled the medical doctors to keep close control over the midwives and their training [61]. Throughout the late 1880s and 1890s midwifery training was increasingly incorporated into nursing. Henceforth the term 'obstetrical or obstetric nurse' became popular. Midwifery training began to be offered but was offered only to qualified nurses where it was available in New South Wales from the 1880s and in South Australia from 1902 [6,10] it was also decided that only those with general nursing training could be employed in a hospital's midwifery department [10,61].

The introduction of these medically-run, midwifery training schools created a new type of midwife, who specialised in hospital-based midwifery and therefore was familiar with the medical model of care. This contributed to the divide between hospital-based midwives and the independent midwife. The working-class independent midwives were also seen as a hindrance to the new nurses and were excluded from many training schools due to their social class and age. They did not fit the new image of the trained nurse-midwife [15].

Formal midwifery education commenced in WA in 1909 and was controlled by medical doctors and nurses [15,32]. After debate and discussion, the first government Maternity Training School was established in the former Old Women's Home in Fremantle [32]. Prior to the establishment of the official Fremantle course, some doctors such as Dr Haynes had provided unofficial training to midwives. With the increase in demand for skilled birth attendants it was important that more midwives were trained and subsequent state legislation made the provision of midwifery training essential [15].

The course at Fremantle was run by Dr Williams and supported by a board consisting of a group of doctors known as the 'Fremantle medical men' [15]. These men decided on the requirements of admission. Thus, as in other states, the requirements for admission were prohibitive for many poor, older, working-class women. The WA government was under pressure to train midwives due to the perceived role of untrained midwives in increasing infant mortality, therefore, in contrast to the Eastern State's midwifery schools, applicants did not need to have formal nursing education [15]. Applicants, however, had to be aged between 24 and 45, which excluded many of the existing empirically trained midwives from seeking formal midwifery education. The applicants were required to provide a letter, signed by a clergy man, declaring them to be of moral character and physical fitness. The fee for training was initially ten pounds, but was later reduced to three pounds to attract more applicants [15].

The Fremantle midwifery course was based on similar British courses and initially lasted six months, increasing to 12 months in 1912. It consisted of a series of ten lectures and clinical instruction covering topics such as anatomy and physiology of the female pelvis, normal and abnormal labour, antisepsis and care of the newborn [15]. All lectures and clinical instruction were conducted by doctors. In addition to the theory, midwifery students were required to attend and assist the doctor at 20 labours and births and complete an examination paper. Once training was completed, the midwife received a certificate and thus became a certified midwife. Initially the demand for the course was very low, however following the implementation of legislation requiring registration of midwives, demand increased [15].

Midwifery education continued at the Fremantle School until 1916, when it was transferred to the newly opened King Edward Memorial Hospital (KEMH) for women. The length of training was dependent on whether the student was already a trained nurse; six months for students who had completed three years of general training and 12 months for non-nurse applicants. The fee was ten pounds and the eligible age was extended to 21–45 [15,32,36]. Although the course was available to older women, the requirement for students to live on site, ruled out older married working-class women being able to access training [15,32,62].

15. Education of midwives in WA 1950−2020

Midwifery education continued to be solely offered via hospital-based training until the mid-1980s when university-based education was introduced, however, both types of training were offered until the early 1990s. The only way to become a midwife in WA during this time period was to first complete nursing education and then apply to complete a recognised midwifery program [16]. Being able to offer a course where non-nurses could become midwives was achieved following the implementation of the *Nurses and Midwifery Act 2006,* as prior to this legislation there was no provision on the nurses register for midwives who were not nurses to be registered [65]. At present (2021) there are three WA universities offering four different pathways to becoming a registered midwife in WA. Two WA universities, offer post graduate education to registered nurses wishing to become midwives. One WA University also offers a four-year double degree, leading to registration as both a nurse and a midwife. Another university offers a graduate entry degree leading to midwifery registration for students holding an undergraduate degree that does not have to be nursing. For WA residents wishing to study only undergraduate midwifery, they must enrol to study with a university not based in WA.

16. Impact of the Australian Trained Nursing Association

The first Australian nursing association, the Australian Trained Nursing Association (ATNA) [66], was established in New South Wales in 1899 with other branches developing throughout Australia: Queensland in 1904; South Australia in 1905; WA in 1907; and Tasmania in 1908. Victoria had formed its own nursing association, the Victorian Trained Nursing Association (VTNA) [67] in 1901, which worked closely with the ATNA. The formation of these associations, like the medical associations, was a move to develop nursing as a profession and gain higher social standing. Although it was not compulsory to be a member, membership was recognised as a status symbol [32]. ATNA was also established to promote the interests of all trained nurses, and their aim was to establish a system for registration, another step towards professionalisation and provide accepted standards of education. Only nurses trained at ATNA accredited hospitals were able to become members once they had completed their training. This led to greater associations between the ATNA approved training hospitals and the nursing association, which enabled them to establish nursing training standards throughout Australia. ATNA also developed and published a journal; *The Australasian Nurses' Journal*. The KEMH midwifery school was recognised by the Australian Trained Nursing Association (ATNA), enabling midwives who had trained at KEMH to become members and increased the power of the ATNA over midwifery in general [32].

17. The formation of associations and colleges

From the 1970s the International Confederation of Midwives (ICM) have supported the concept that the midwife is an autonomous health professional. Following a group of Australian midwives attending an ICM meeting in 1975, Australia was asked to become a member of the ICM [68]. This inclusion contributed to the formation of the Australian College of Midwives Incorporated (ACMI). The ACMI was founded nationally in 1987, when midwifery associations in several states and territories came together to create a national peak body for Australian midwives [68].

Various medical groups and associations have existed in Australia since the 1800s. In 1962 these merged to become the most powerful professional medical organisation in Australia, the Australian Medical Association (AMA) [69]. The AMA has substantial influence on the legislation, division and distribution of health care. From the early 19th century Australian doctors were members of the British Colleges however it was not until the 1940s that Australia formed their own branch of the Royal College of Obstetricians and Gynaecologists (RCOG) [69].

Australian obstetricians remained members of the British College until 1978 when they established their own college, The Royal Australian College of Obstetricians and Gynaecologists [69]. In 1998 they amalgamated with New Zealand and became the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) [69]. The RANZCOG has many guidelines and position statements that guide medical practitioners and has a profound influence on midwifery practice not only in the institutions but also by being involved in the decision making around policies and guidelines.

18. Midwifery in WA 1950−2020

Legislation to control midwifery continued throughout the second half of the 20th century with regular updates and amendments to The *Health Act of 1911* [57]. These changes included who the midwife must inform of her intention to commence private practice, the situations when a midwife must consult a medical practitioner; what drugs the midwife could and could not administer; the contents of her midwifery bag; and the required paperwork to complete [57,58,72–75]. From the 1930s most women in WA gave birth in hospital; women still received midwifery care from midwives, although the care administered was ordered and directed by doctors. The medicalisation of birth was becoming the norm in most Western countries, and although midwives were still autonomous practitioners in some countries this was not the case in Australia. However, some midwives did work privately and attended homebirths during this time, but there are few records available [36].

In Australia, the state-supported health system's main aim is to provide state funded services for those who do not have private insurance. The development of Medibank, Medicare and the compulsory health insurance schemes of the 1970s and 1980s led to many women choosing to birth in a private maternity hospital under the care of a private obstetrician [68]. Medicare began in 1984 and is the Commonwealth funded health insurance scheme that provides free or subsidised health care services [76]. It provides free hospital services for public patients and subsidises some private medical costs. Medicare coexists with a private health system.

Community-based services have mostly been ignored by government, and state funding has been linked to large tertiary hospitals, directing a centralisation of services and the closure of many smaller hospitals [16]. Historically, women wanting to give birth in an out-of-hospital setting in WA had few options and there were no government funded options until the early 2000s [16]. The AMA and RANZCOG consistently argued that the care of women during pregnancy, labour and birth is appropriately given only by a doctor, and this rhetoric strengthened the belief that birth was safest in hospital and doctors were the appropriate maternity care providers [70]. For Australian women, attempting to choose care from a midwife was considered a radically different choice compared to the mainstream options of medicalised birth in a private or public hospital, under care directed by an obstetrician.

By the mid-1970s consumer and political pressure for birthing alternatives began to mount in Australia. Homebirth continued to be strenuously opposed by the medical profession [68]. Until the 1990s the only non-medicalised option for women in WA was a homebirth with a Privately Practising Midwife (PPM). Unfortunately, this option was not available for many women as cost, access and availability of PPMs were prohibitive factors. Another less 'radical' option for women wanting a non-medicalised and physiological birth was to give birth in a birth centre [16]. Birth centres in Australia are generally managed by obstetricians, who decide who can and cannot birth there [16]. The centres are usually attached to hospitals, thus enabling quick access to the 'safety' of the hospital and the supervision of the doctors [77]. In 1989, The Alternative Birthing Services Program (ABSP), a Commonwealth government initiative, aimed to provide funding to develop alternative birth choices for women including birth centres and homebirth [16]. Many planned programs across Australia were not implemented and ones that were did not continue once the ABSP funding ran out [16].

In WA two alternative birth service initiatives received commonwealth funding. These two alternative birth services were the Family Birth Centre (FBC) and the Community Midwives Program (CMP) [16]. The FBC opened in 1992 [78] and was the first government funded birth centre in WA. The FBC is situated on site at KEMH, and only women classed as 'low risk' can birth at the centre. The classification of 'risk' is problematic, as it has been, and continues to be, a continually changing classification defined by the obstetric profession and not by midwifery or women themselves. The Community Midwives Program (CMP) was the result of many years of lobbying by midwives providing homebirth services to women privately and was the first government-funded homebirth program in Australia [16]. The CMP has many restrictions on the women that can access this service.

19. The Maternity Service Review

In 2009 the Australian government released a report aiming at improving maternity services across Australia [79]. *The Maternity Service Review* [79] report included many midwifery related recommendations including increased maternity care options for women such as midwifery-led care and increasing the scope of practice for midwives.

In relation to midwifery the report recommends (1) changes to improve choice and availability of a range of models of maternity care for Australian mothers by supporting an expanded role for midwives, including consideration of changes to Commonwealth funding arrangements and support for professional indemnity insurance for midwives and (2) changes including an expanded role for midwives to take place within a strong framework of quality and safety [79 (p .2)].

It is clear from the foreword written by Rosemary Byrant, the Commonwealth Chief Nurse and Midwifery Officer, that the report highlighted problems between the midwifery and medical professions:

> there is a lack of unanimity within and between some groups of the medical and midwifery professions on the issue of how to deal with risk and consumer preferences. While it is acknowledged that safety and quality of care is an overarching goal, it would be remiss to always use it as an excuse not to change practice. In maternity services, where most pregnancies follow a normal pattern, we must ensure, first, that practice is based on evidence and, second, that we are not allowing our safety and quality concerns to prevent us acting on evidence that supports changes to practice. Risk must always be a carefully monitored balance of safety and informed choice [79 (para iii)].

Unsurprisingly, the report did not include homebirth in its recommendations, highlighting the power and influence of the medical profession on government policy. Prior to the report being developed, consultation was sought from stakeholders and consumers. The subsequent submissions included over 470 responses from the 900 received that specifically called for funding and homebirth options for women. According to the report, many of the consumers who participated in the review consultations had strongly held views about government funding for midwifery-led models of care including homebirth, and many submissions included evidence of positive outcomes [79].

The report stated that it did not include homebirth in its recommendations as homebirth in Australia is "a sensitive and controversial issue" and that "the relationship between maternity health care professionals is not such as to support homebirth as a mainstream Commonwealth-funded option" [79 (p.21)]. It also stated that providing funding for homebirth had the potential to polarise the professions rather than allowing for an expansion of collaborative approaches [79 (p.21)]. This drew criticism as it highlighted that rather than responding to the submissions and clear evidence of homebirth's safety, the report held the medical profession's views that homebirth is unsafe, and that

midwives are unable to work autonomously. Consequently, the decision by the report's authors to not deal with the issues relating to homebirth reinforces the hierarchal nature of obstetric care in Australia.

One of the key recommendations and a promising step forward for midwifery were the recommendations that the government would support "an expanded role for appropriately qualified and skilled midwives, within collaborative team-based models" to access the Pharmaceutical Benefits Scheme (PBS) enabling midwives to provide prescriptions for women in their care and the Medicare Benefits Schedule (MBS) and allow women who received care from a midwife to be reimbursed for some of the cost associated with their care [79 (p.52)]. One of the concerns, was the need for collaboration with the medical profession, who opposed the recommendations to increase the scope of the midwife.

Following the release of the Maternity Service Review [79], government reforms were legislated to enable eligible midwives and their clients to access the PBS and MBS. In November 2009, the introduction of more legislation occurred: The Health Legislation Amendment (Midwives and Nurse Practitioners) Act 2010 [80]; Midwife Professional Indemnity (Commonwealth contribution) Scheme Act 2010 [81]; Midwife Professional Indemnity (Run-off Cover Support Payment) Act 2010 [82] and in WA, the Health Practitioner Regulation National Law (WA) Act 2010 [83] replaced the Nurses and Midwifery Act 2006 [65].

On November 1st, 2010, the first eligible Australian midwives received medical provider numbers and were able to apply for endorsement to prescribe scheduled medicines. To obtain endorsement the midwives had to meet the eligibility criteria which included proving competence across the continuum of midwifery practice, the completion of a pharmacology, diagnostic and screening education program and providing evidence of collaboration with a medical practitioner. This created another type of midwife — an endorsed midwife — and as seen throughout the history of midwifery, midwives again had to prove their 'eligibility' to be able to provide autonomous midwifery care. Since its implementation, the process has also undergone some adjustments, which included a clause that midwives must have midwifery experience, the equivalent of three years full time post registration as a midwife to be able to apply for endorsement. Endorsed midwives must also complete regular professional practice peer reviews (every three years) and complete an additional 20 h of continuing professional development per year [84].

In 2010, Australia's health regulatory system underwent substantial changes. A National Registration and Accreditation Scheme (NRAS) was created. This change saw the consolidation of 75 Acts of Parliament and 97 separate health profession boards across eight States and Territories into a single National Scheme [80]. The National Scheme set a minimum standard for safe practice by health professionals [85]. Prior to 2010, each of the Australian states had its own registration scheme for health practitioners and with this a total of 85 professional boards and 66 Acts of Parliament to govern the implementation of legislation in each jurisdiction. With the introduction of the new legislation the National Registration and Accreditation scheme was implemented. In July 2010, the Australian Health Practitioner Regulation Agency (AHPRA) was created as the managing body to support the newly formed health professional registration Boards of Australia. AHPRA, and is governed by the Health Practitioner National Law Act, 2009 [85]. This law means that for the first time in Australia 15 health professions are regulated by one national legislation. The objective of the *Health Practitioner National Law (2009)* [83] is to establish a national registration and accreditation scheme in order to meet the following objectives: provide protection for the public; enable workforce mobility and remove the administrative burden for practitioners; facilitate high quality education and training to health professionals; assess overseas trained health professionals; facilitate access to health services for members of public and continue to develop a flexible, responsive and sustainable Australian Health workforce [83 (p.229)].

20. The Nursing and Midwifery Board of Australia (NMBA)

The Nursing and Midwifery Board of Australia (NMBA) [86] regulates the practice of nursing and midwifery in Australia, and one of its key roles is to protect the public. The NMBA does this by developing registration standards, professional codes, guidelines and standards for practice which establish requirements for the professional and safe practice of nurses and midwives in Australia [87]. Following the formation of the NMBA, midwifery was recognised as a separate profession in Australia, however it is still aligned with nursing.

21. Insurance

In the 1990s PPMs could access private indemnity insurance (PII) [16 (p.195)], but following the 2001 insurance crisis in Australia, many insurance companies increased their insurance premiums to an unaffordable level and midwifery insurance ceased to be offered in any form. The Australian government intervened to assist medical doctors in subsidising their insurance premiums, however, no such offer was made to midwives [79]. Midwives continued to provide private midwifery care but practiced without insurance. In 2009 The *Maternity Service Review* stated:

> midwives who provide support for birthing privately do so without professional indemnity insurance. This means that they do so at their own financial risk or, depending on the midwife's financial circumstances, the risk transfers to their clients should an adverse event occur, leaving a woman with no recourse to financial compensation. A situation where a health professional operates without appropriate professional indemnity cover is not considered acceptable [79 (p.54)].

With the implementation of the Health Practitioner National Law Act, 2009 [88] all registered health professionals were required by law to hold private indemnity insurance (PII). For employed midwives, the insurance was supplied by their employer, however for self-employed PPMs no insurance product existed. Recommendation 18 of the Maternity Service Review stated:

> That, in the interim, while a risk profile for midwife professional indemnity insurance premiums is being developed, consideration be given to Commonwealth support to ensure that suitable professional indemnity insurance is available for appropriately qualified and skilled midwives operating in collaborative team-based models. Consideration would include both period and quantum of funding. Private Indemnity Insurance (PII) is a requirement of all registered Midwives providing private care. PII is designed to assist in paying for legal costs and potential damages [79 (p.55)].

Initially two insurance products were made available, Vero and Medical Insurance Group Australia (MIGA). However, Vero ceased to offer insurance to midwives in 2015 as they stated it was not a viable option [89]. Following the withdrawal of Vero, the only insurance product available for midwives was MIGA [90]. This was problematic as MIGA only provided insurance for midwives who had completed the eligible midwife requirements [90]. Therefore, some midwives in private practice were unable to gain insurance and were forced to cease working as a PPM. Neither Vero, when it was available, nor MIGA offers insurance for homebirth; since 2010, Section 284 of the National Law gives PPMs who provide midwifery care at homebirths an exemption from needing PII insurance for intrapartum care at home until a suitable option is found [87,91]. For midwives to be exempt they must have no restrictions on their registration that prevents them from attending homebirths; informed consent must be given by the woman and the midwife must practice in accordance with the codes and guidelines of the profession as set out by the NMBA [91]. This exemption has been extended on two occasions and is currently in place until the 31st of

December 2021. This situation is problematic as it leaves homebirth midwives and women uninsured.

22. Collaboration between midwives and doctors

In January 2004 the first edition of the Australian College of Midwives *National Midwifery Guidelines for Consultation and Referral* was released [92]. The aim of these guidelines were to "provide an evidence based, national framework for consultation and transfer of care between midwives and doctors" [92 (p.6)]. These guidelines were developed to assist midwives to decide when it was appropriate for them to discuss care with a colleague, medical doctor or specialist obstetrician, and when indicated, transfer the care to a medical specialist [92]. If a complication or abnormality is found or presents during the woman's care, the guidelines recommend that the midwife take one of three main steps: discuss the issue/condition with another midwife and/or with a medical colleague; Consult with a medical practitioner; and Transfer responsibility for the woman's care to a medical specialist [92 (p.11)]. *The National Midwifery Guidelines for Consultation and Referral* is now in its third edition, which has been 'endorsed' by RANZCOG and the Australian College of Midwives (ACM). The third edition is more detailed in defining the midwives' scope of practice and what is considered normal and abnormal during pregnancy, labour and birth and the postnatal period however changes have reduced the midwives' scope of practice even further [93].

The requirement to have collaborative arrangements has been problematic with many GPs and obstetricians refusing to enter into a collaborative arrangement with midwives. This led to a change in the wording of the requirement, which now states that midwives may have a collaborative agreement with a health facility rather than an individual [94]. The requirement of collaboration remains problematic because the lack of support for autonomous midwifery practice and homebirth by doctors has led to distrust between them and a lack of understanding of the scope of midwifery practice.

23. Conclusion

The aim of this paper was to gain insight into the history of midwifery in WA. Understanding the development and evolution of the midwifery profession in Australia can help future directions of the profession. McKenzie [15] asserts that in studying the previously untold history of women and midwives "the past begins to have greater relevance in the present and the links between women's past experiences and the experiences of modern-day mothers can be seen more clearly" [15 (p.190)]. From the early 20th century, when birth moved into the hospital, midwives in WA have been incorporated into the hierarchy of the professions with obstetrics as the lead profession and midwifery considered a speciality of nursing [15,63]. This paper has highlighted how the role of the midwife has been subordinated, initially controlled by medicine and then incorporated into the institutions and nursing. The increase in legislative and training requirements for midwives throughout Australia and the move from home to the hospital, gradually led to the decrease in midwives working within the community, impacting women's choice of birth attendant and place of birth [10,11,56]. Davies [11] explored the factors that underpinned the regulation of midwifery practice in Queensland in the early 20th century and found that the power of the 'institutions', in this case the medical profession and the state, were main influences on the regulation of midwives. Historically, midwives were not formally trained, but empirically trained and were able to be controlled due to their class and sex, being poor, older and working-class women [11]. The historical suppression of midwifery in Australia has impacted the understanding of the role of the midwife in the contemporary setting. The suppression of midwifery is not a new concept, however this paper highlights that the dominance of the patriarchal medical model continues to suppress midwifery leading to a reduction of women's autonomy. There is a need to act before midwifery as an autonomous profession ceases to exist in Australia.

Ethical statement

Ethical approval for the PhD was obtained however this is a historical discussion paper.

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